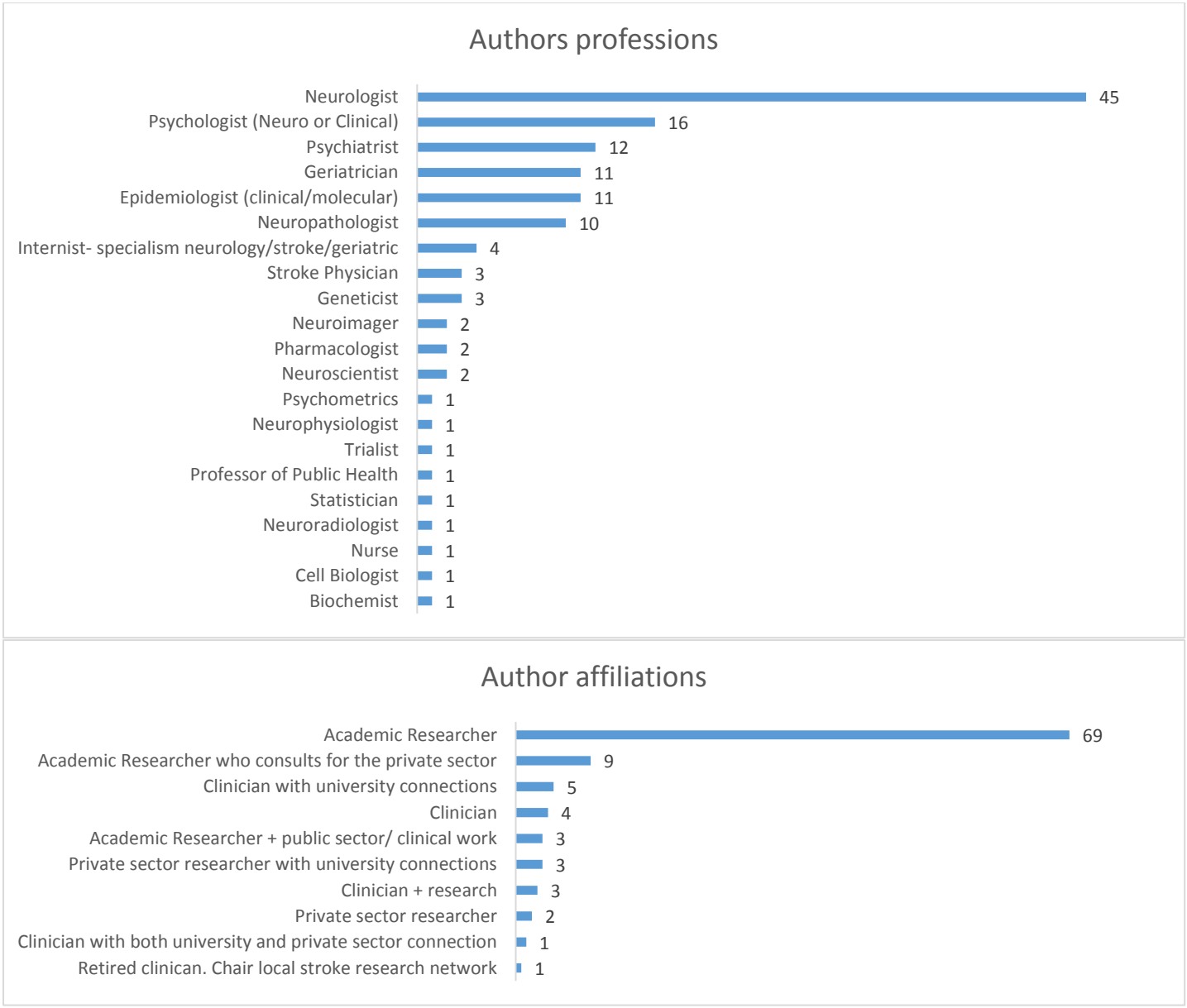

Supplementary Figure 1: Authors professions and affiliations. Data taken from the invitation survey prior to the Delphi surveys. Note that more than one profession could be selected or provided per respondent. Data shown as percentage of the number of authors (n=153)

Rounds	Number of Respondents	Clinical	Non-clinical	Continent	Area of interest	Overlap
1	73	51 (70%)	22 (30%)	Africa 3%; Asia 14%; Europe 67%; North America 10%; South America 7%	Clinical trials 10% Diagnostics 40% Epidemiology 18% Rehabilitation 12% R&D 21%	
2	73	50 (68%)	23 (32%)	Africa 4%; Asia 10%; Europe 66%; North America 16%; South America 4%	Clinical trials 12% Diagnostics 40% Epidemiology 16% Rehabilitation 11% R&D 21%	55 (75%)
3	68	44 (65%)	24 (35%)	Africa 4%; Asia 10%; Europe 63%; North America 18%; South America 4%	Clinical trials 12% Diagnostics 39% Epidemiology 17% Rehabilitation 9% R&D 23%	64 (94%/84%)
4	73	50 (68%)	23 (32%)	Africa 4%; Asia 10%; Europe 64%; North America 18%; South America 4%	Clinical trials 12% Diagnostics 32% Epidemiology 18% Rehabilitation 15% R&D 23%	67 (92%/81%)
5	65	41 (63%)	24 (37%)	Africa 3%; Asia 11%; Europe 65%; North America 15%; South America 6%	Clinical trials 12% Diagnostics 35% Epidemiology 18% Rehabilitation 12% R&D 22%	63 (97%/89%)
6	79	59 (75%)	20 (25%)	Africa 3%; Asia 9%; Europe 67%; North America 18%; South America 4%	Clinical trials 11% Diagnostics 39% Epidemiology 18% Rehabilitation 13% R&D 19%	71 (90%/76%)

Supplementary Table 1: Participants in each Delphi round. Surveys were answered anonymously. The data presented is from participant selection of the provided 'login' options for each survey; whether their work is predominantly clinical or non-clinical, in which continent they reside, and selected area of interest from the five provided options. As part of the login participants also provided a memorable date and first initial. Participant overlap from any previous round/previous round only has been estimated from the login data and may therefore be higher due to login selection variance from the same participant.

Criteria	Current Use	Ease of use	Usefulness
NINDS-AIREN (Roman et al., 1993)	59%	5. (68%)	2. (50%)
DSM-IV (American Psychiatric Association, 1994)	40%	2. (74%)	5. (34%)
Hachinski Ischemic Scale (Hachinski et al., 1975)	33%	1. (84%)	8. (26%)
ICD-10 (World Health Organisation 1992/93)	23%	4. (69%)	6. (28%)
Research criteria subcortical VaD (Erkinjuntti et al., 2000)	18%	6. (65%)	3. (43%)
NINDS-CSN standards (Hachinski et al., 2006)	15%	8. (61%)	1. (55%)
ADDTC (Chui et al., 1992)	10%	12. (45%)	12. (22%)
VCI-ND subtypes (Cao et al., 2010)	5%	13. (37%)	4. (36%)
VaD neuropathology (Kalaria et al., 2004)	5%	15. (29%)	10. (24%)
Mayo clinic criteria (Knopman et al., 2002)	3%	3. (70%)	11. (24%)
Diagnostic algorithm for VCI (Zhao et al., 2010)	3%	9. (53%)	7. (28%)
Ischemic Scale of Rosen (Rosen et al., 1980)	3%	7. (63%)	14. (10%)
Subcortical vascular dementia (Price et al., 2005)	2%	14. (37%)	9. (25%)
DSM-IIIR (American Psychiatric Association, 1987)	1%	10. (51%)	13. (11%)
DSM-III (American Psychiatric Association, 1980)	0%	11. (48%)	15. (7%)

Supplementary table 2: Summary results from Foundation round 1 regarding; current use, ease of use and usefulness of the diagnostic criteria. The criteria are listed in terms of most to least used at the time of survey. We asked participants to rate the criteria on how easy they were to use with the following options: "no longer relevant", "extremely hard", "not very easy", "relatively easy" and "very easy". For each criteria we combined the scores for "relatively easy" and "very easy" to give an "Easy to use" rating. We compared this rating with the total number of ratings, to provide a percentage score for "Ease of use". The criteria are ranked in order of "Ease of use". Participants were asked to rate the criteria in terms of usefulness for the diagnosis with the following options: "No longer relevant", "Not useful at all", "Of limited use", "Useful in most cases", "Useful in all cases". For each criteria, we combined the ratings for "Useful in Most cases" and "Useful in all cases" to give a "Usefulness" rating. We compared this with the total response to give a percentage "Usefulness" rating. The criteria are ranked based on the percentage "Usefulness" rating. (We also offered options of "Not familiar" and "Unable to comment". These were excluded from the analysis which only includes those who were able to give an informed response)

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Supplementary text 1:

Round 3 participants were asked to agree or disagree with use of each neuropsychological test in the NINDS-CSN guidelines or provide alternatives to be used. Regarding MMSE, 71% support its use as a supplementary test in the 60-minute protocol and 75% in the 30-minute protocol, with only 2 participants stating MoCA as an alternative. Only 23% of respondents stated they used the 5-minute NINDS-CSN protocol. Of these, 67% stated MoCA was useful on its own and 33% in conjunction with another test. In a further question "in light of various copyright issues that have emerged in recent years regarding the MMSE, has the use of MMSE at your centre been stopped?" Only 12% responded Yes and all but one of these stated MoCA was used in its place.

In Round 6, 56% of respondents thought there were already sufficient tools available for the assessment and appropriate scoring of IADL/ADL, with the remainder of respondents supporting this as an area for further research. Those who supported current tools were asked to provide names of appropriate scales. Seventeen different scales were suggested with multiple respondents (>2) proposing: Lawton & Brody; Disability Assessment in Dementia; Bristol ADL; Barthel Activities of Daily Living (ADL) Index; Katz index; Everyday Cognition Scale; The Functional Independence Measure and Functional Activities Questionnaire.

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